

**Kentucky Board of Education**

**Kentucky Department of Education**

**702 KAR 1:160. School Health Services**

**October 14, 2014**

**KENTUCKY DEPARTMENT OF EDUCATION  
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES\***

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M  F

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Applicant With or Employed By \_\_\_\_\_ Board of Education \_\_\_\_\_

**HISTORY**

**Medical** (All serious medical and psychiatric diseases: diabetes, epilepsy, heart disease, etc.) \_\_\_\_\_

**Surgical** (All major operations) \_\_\_\_\_

*"Per the Genetic Information Nondiscrimination Act of 2008, it is unlawful for an employer to request genetic information, genetic testing information, family medical history information, or family genetic testing information from an applicant or employee. The medical provider conducting this examination of an applicant/employee of a local school district shall not request, require or purchase this information about the applicant or employee. Any applicant or employee undergoing a medical examination for employment with a local school district shall not provide this information to the medical provider or the school district."*

**PHYSICAL**

- |                              |                                     |
|------------------------------|-------------------------------------|
| 1. General Appearance _____  | 7. Blood Pressure _____ Pulse _____ |
| 2. Eyes _____                | 8. Lungs _____                      |
| 3. Ears, Nose & Throat _____ | 9. Abdomen _____                    |
| 4. Teeth & Gums _____        | 10. Nervous System _____            |
| 5. Thyroid _____             | 11. Extremities _____               |
| 6. Heart _____               | Other _____                         |

**Tuberculosis Risk Factor Assessment**

- Yes  No  High risk for Tuberculosis infection
- Yes  No  Referred to local health department for further TB infection evaluation
- Yes  No  Tuberculosis test performed (specify: \_\_\_\_\_ TST/ \_\_\_\_\_ BAMT)
- \_\_\_\_\_ Date of chest X-Ray
- No further follow-up unless signs/symptoms of Tuberculosis infection develop

I have examined \_\_\_\_\_ and find him/her free of communicable disease and any physical or mental disabilities that might interfere with performing his/her duties, except as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature (Physician/PA/APRN)

\* School Bus Drivers are required to use form TC94-35E.

**PREVENTIVE STUDENT HEALTH CARE EXAMINATION FORM**

All local boards of education shall require a preventive health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

**PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS**

**IDENTIFYING INFORMATION**

Student Name: \_\_\_\_\_ Gender: M F Grade: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ yrs \_\_\_\_\_ months Preferred Language: \_\_\_\_\_  
 Parent or Guardian Name: \_\_\_\_\_

**RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.**

**MEDICAL HISTORY**

Allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Prescribed Medications to be taken daily at school: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Significant Historical Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SCREENING RESULTS:**

BP: \_\_\_\_\_ Height: \_\_\_\_\_ (ft.) \_\_\_\_\_ (inches) Weight \_\_\_\_\_ lbs. BMI \_\_\_\_\_ BMI% \_\_\_\_\_

|        |                |                                   |                 |                                 |                                 |                                   |
|--------|----------------|-----------------------------------|-----------------|---------------------------------|---------------------------------|-----------------------------------|
| Vision | Right 20/_____ | Passed <input type="checkbox"/>   | Hearing - Right | Passed <input type="checkbox"/> | Failed <input type="checkbox"/> | Referred <input type="checkbox"/> |
|        | Left 20/_____  | Failed <input type="checkbox"/>   |                 | Hearing - Left                  | Passed <input type="checkbox"/> | Failed <input type="checkbox"/>   |
|        |                | Referred <input type="checkbox"/> |                 |                                 |                                 |                                   |

Optional: Hct/HGB: \_\_\_\_\_ Lead: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

- General appearance  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_
- Gross dental (teeth and gums)  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_
- Head/scalp/skin  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_
- Eyes/Ears/Nose/Throat  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_
- Chest/Lungs/Heart  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_
- Abdomen/Genitalia  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_
- Extremities/back  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_
- Neuro  Normal  Abnormal \_\_\_\_\_ Refer/Tx: \_\_\_\_\_





DOCUMENTATION

Use this side to record referrals and follow-ups (*physician, clinic, parent, etc.*), special procedures required during the school day, or other significant findings that may affect the student's school participation. Please sign and date all entries.

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**PUPIL'S CUMULATIVE HEALTH RECORD**

The purpose of this record is to give the health professional a concise summary of the student's school health history. It is not intended to be used for daily documentation. Parent and emergency information should be maintained elsewhere.

Screenings are recorded by date and student age rather than grade level. This accommodates changes in the primary program and documents information more accurately for the student.

KRS 156.160 (1) (i) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

**PLEASE COMPLETE THE IDENTIFYING INFORMATION**

Date of student's enrollment: \_\_\_\_\_

Date of Vision Examination: \_\_\_\_\_

**IDENTIFYING INFORMATION**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

**CASE HISTORY**

Date of Exam: \_\_\_\_\_

Ocular History: Normal or Positive for: \_\_\_\_\_

Medical History: Normal or Positive for: \_\_\_\_\_

Drug Allergies: NKDA or Allergic to: \_\_\_\_\_

Family Ocular and Medical History:  Amblyopia  Strabismus  Glaucoma  Diabetes

Other: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

Refraction with cycloplegic? (Please indicate one.)  YES  NO

|                       |           |           |
|-----------------------|-----------|-----------|
|                       | <b>OD</b> | <b>OS</b> |
| Unaided Acuity        | 20/       | 20/       |
| Best Corrected Acuity | 20/       | 20/       |

| Type of Examination                      | Normal | Abnormal | Notable to Assess |
|--|--------|----------|-------------------|
| External Exam (eye and adnexa)           |        |          |                   |
| Internal Exam (media, lens, fundus, etc) |        |          |                   |
| Neurological Integrity (pupils)          |        |          |                   |
| Binocular Function (stereopsis)          |        |          |                   |
| Accommodation and convergence            |        |          |                   |
| Color Vision                             |        |          |                   |

**Diagnosis:**

Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other: \_\_\_\_\_

**Recommendations:**

1 Glasses prescribed:  YES  NO

2 \_\_\_\_\_

3 \_\_\_\_\_

**Age appropriate and suggested anticipatory guidance (health assessments):**

- Educate (parents/patients) about eye/vision disorders and needed vision care
- Counsel (parents/patients) regarding eye safety
- Stress importance of early, preventative eye care
- Recommend re-examination, as appropriate

Signed: \_\_\_\_\_  
Optometrist/Ophthalmologist

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Kentucky law, KRS 156.160(f), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced practice registered nurse, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

|  |   |  |
|--|---|--|
| <b>Student Name:</b> _____<br>Last _____ First _____ Middle _____<br>Birth date: ____ / ____ / ____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female    |   | Test Type (check one)<br><input type="checkbox"/> Screening<br><input type="checkbox"/> Exam   |
| Parent or Guardian: _____<br>Name _____ Relationship _____<br>Address: _____ City: _____<br>Phone Number: _____ School: _____<br>Date of Exam/Screening ____ / ____ / ____       |   | <b>Screener's Name:</b> _____<br>Screener's Address: _____<br>Phone Number: _____ Screening Date: _____<br>Screener's Signature: _____   |
| <b>Untreated Decay:</b> (Check one)<br><input type="checkbox"/> 0 No untreated cavities<br><input type="checkbox"/> 1 Untreated cavities   | <b>Treated Decay:</b> (Check one)<br><input type="checkbox"/> 0 No treated cavities<br><input type="checkbox"/> 1 Treated cavities  | <b>Professional affiliation: (Please check one)</b><br><input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist<br><input type="checkbox"/> Physician Assistant <input type="checkbox"/> *Registered Nurse<br><input type="checkbox"/> APRN <input type="checkbox"/> Physician |
| <b>Pattern of Early Childhood Cavities:</b> (Check one)<br><input type="checkbox"/> 0 No Early Childhood Cavities<br><input type="checkbox"/> 1 Early Childhood Cavities Present | <b>Treatment Urgency:</b> (Check one)<br><input type="checkbox"/> 0 No obvious problem<br><input type="checkbox"/> 1 Early dental care needed<br><input type="checkbox"/> 2 Referral for Urgent Care<br>NOTE: Comment required if marked. | <b>Comments:</b> _____   |

OH-12  
 Note: It is the RNS responsibility to consult the KBN Scope of Practice before conducting screenings.